CHILD CARE ACCIDENT REPORT FORM

Please return to Clay County Licensor within 24 hours of injury.

DATE	
CHILD CARE PROVIDER	
ADDRESS	
TELEPHONE NUMBER	
CHILD(REN) INJURED	
NATURE OF INJURY	
DATE OF INJURY	
MEDICAL TREATMENT REQUIRED	☐ **Yes** ☐ **No**
If Yes List Doctor and/or Hospital, If Known	
Parent(s) of Child Notified	☐ **Yes** ☐ **No**
Parent(s) Name	
Parent(s) Address	
Parent(s) Telephone Number(s)	

_____ _____

Signature of Child Care Provider **Date**

_____ _____

Signature of Parent **Date**